

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12945

12945

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY Queen Anne Church Hill 17x-2					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Easton		c. LENGTH OF STAY IN 1b 4 1/2 da		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hosp. tal											
3. NAME OF DECEASED (Type or print)		First W.	Middle Edwin	Lost Atkinson	4. DATE OF DEATH 11 25 1958	Month 11	Day 25	Year 1958			
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1920	9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Louis H. Atkinson		14. MOTHER'S MAIDEN NAME Florence Luther				Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause lost. (b) Carcinoma of the stomach DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 months	
										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy	20d. INJURY OCCURRED While not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 202 Dover St.	(County)	(State)			
21. I certify that I attended the deceased from alive on		Nov. 20, 1958, to November 25, 1958, that I last saw the deceased 11-25, 1958, and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 202 Dover St.									
ACTUAL SIGNATURE Robert W. Trevor		DATE SIGNED 11-25-58									
PHYSICIAN'S NAME (Type) Robert W. TREVER											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/58		22c. NAME OF CEMETERY OR CREMATORIUM Crompton Cemetery		22d. LOCATION (City, town, or county) Crompton		(State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE Elga L. Lane		ADDRESS Church Hill		24a. REC'D BY REGISTRAR DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WYOMING STATE DEPARTMENT OF HEALTH - DEATH CERTIFICATE

CERTIFICATE OF DEATH

100-1000

DEATH CERTIFICATE

DEATH

DEATH CERTIFICATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

18
FOR STATE
HEALTH DEPT.

Item 18 Film 236 11-20-58 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Jaibat</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Longwoods</i>		b. COUNTY <i>Jaibat</i>	
c. LENGTH OF STAY IN 1b <i>3 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Longwoods, Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Marta</i>	Middle <i>Gertude</i>	Last <i>Cecilian</i>	4. DATE OF DEATH Month <i>Nov.</i> Day <i>12</i> Year <i>1958</i>
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5. SEX <i>F.</i>	6. COLOR OR RACE <i>70.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>July 15 1933</i>	9. AGE (in years last birthday) <i>25 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Post Mistress</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Post Office</i>	11. BIRTHPLACE (State or foreign country) <i>Jaibat, L. Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
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13. FATHER'S NAME <i>Harold W. Herward Sr.</i>	14. MOTHER'S M AIDEN NAME <i>Gertude M. Brown</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>	16. SOCIAL SECURITY NO. <i>314-30-7979</i>	17. INFORMANT <i>Geo. R. Cecilian</i>	Address <i>Longwoods, Md.</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH <i>Immed.</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
	<i>19</i>		

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>Laura Whetley</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>11-14-58</i>
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EXAMINER'S NAME (Type) <i>Whetley</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
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22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>100-15-58</i>	22b. DATE THEREOF <i>100-15-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Longwood</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore</i> <i>Md.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Whetley</i>	ADDRESS <i>Arthur S. Kimes</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 17 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kimes</i>
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12948

12946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Talbot MARYLAND		MARYLAND Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Eastern		2 da. 21 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Memorial Hosp. tal		203 Broadway -	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle		Month Day Year	
William Lee		11 - 3 - 58	
5. SEX		6. COLOR OR RACE	
M		W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/>		Sept. 22, 1884	
DIVORCED <input type="checkbox"/>		74 yrs.	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Postal Mail Carrier		Retired	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Edward Spencer Clough		MARY Elizabeth Ringgold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
No		220-09-1849	
17. INFORMANT		Address	
Mrs Paul L. Howard		286 H. Neptune, Ridgewood, N.J.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Diseased intestinal hemorrhage	
541.0		Diseased ulcer	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO	
(b)		DUE TO	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____ and that death occurred at _____, 19_____, from the causes and on the date stated above. ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) DATE SIGNED	
E. C. H. Schmidt		219 S. Washington St., 3 Nov 58 Baltimore 16, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Nov 6-1958	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Chesterfield		Centreville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE NOV 6 '58	
J. Smith, Director, of Burton Bros., Centreville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12947

CERTIFICATE OF DEATH

Reg. Dist. No.

12949

DO NOT RETAIN PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DO NOT FURNISH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE									
Calvert				Maryland b. COUNTY Calvert									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Eastern		29		40 Eastern Maryland									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1. 3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Memorial Hospital		First Elmer H		107 Goldsborough St.						Month November Day 9 Year 1958			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.			
Male		W.				9-17-1889		69 yrs.		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Night Clerk				Maryland		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Garrison R. Collins		Elmira Merrick											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
(Yes, no, or unknown)		213-22-8582		Mrs. Henry Purdy		Easton, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		Cerebral thrombosis						yrs.					
332X													
DUE TO													
Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause lost.		(a) Cerebral thrombosis											
(b)													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED?					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 10/11/1958, to 11/9/1958, that I last saw the deceased alive on 9/25/1958, and that death occurred at 5:10 A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE		Maurice S. Newmark						Calvert Maryland		11/10/58			
PHYSICIAN'S NAME (Type)		THORSTON HARRISON											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)					
Burial		Nov. 11, 1958		Spring Hill Cemetery		Easton, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Maurice S. Newmark		1520 Easton, Md.		NOV 12 '58		Arthur S. Thomas							

~~61~~ FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12948 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12950

Reg. Disf. No.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15MI
5M 2/57

<p>1. PLACE OF DEATH o. COUNTY TALBOT</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON</p> <p>c. LENGTH OF STAY IN lb 1 1/2 hrs</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND</p> <p>b. COUNTY TALBOT</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON</p> <p>d. STREET ADDRESS 301 OAK AVE</p>				
<p>3. NAME OF DECEASED (Type or print) Peggy</p>		First June	Middle 	Lost 	4. DATE OF DEATH DIETER	Month NOV	Day 22	Year 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1926	9. AGE (In years <i>Jan birthday</i>) 32	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary	11. KIND OF BUSINESS OR INDUSTRY Insurance	12. BIRTHPLACE (State or foreign country) Maryland	13. CITIZEN OF WHAT COUNTRY? USA
<p>13. FATHER'S NAME C. C. Chilcutt</p>				<p>14. MOTHER'S MAIDEN NAME Estella Nan Trader</p>				
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no</p>		16. SOCIAL SECURITY NO. u kn	17. INFORMANT Sheldon E. Dietert	<p>Address 301 Oak Ave.</p> <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) Internal hemorrhage</p> <p>816X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Ruptured spleen, hemothorax</p> <p>DUE TO (c) Auto accident</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)</p> <p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) pass in car involved in 2-car collision</p> <p>20c. TIME OF INJURY Month, Day, Year Hour 11:30p o. m. 11-21 1958</p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) road</p> <p>20f. (City or town) nr Easton</p> <p>(County) Talbot</p> <p>(State) Md.</p> <p>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Louis Meeley</i></p> <p>EXAMINER'S NAME (Type) Welty</p> <p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED 11-22-58</p> <p>22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION</p> <p>22b. DATE THEREOF 11/26/58</p> <p>22c. NAME OF CEMETERY OR CREMATORIAL FORT Lincoln</p> <p>22d. LOCATION (City, town, or county) Bladensburg, MD.</p> <p>(State) </p> <p>23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i></p> <p>ADDRESS Arthur S. Kraus</p> <p>24a. REC'D BY REGISTRAR NOV 25 '58</p> <p>24b. REGISTRAR'S SIGNATURE Arthur S. Kraus</p>				
<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>								

Page 5

For the purpose of

SEARCH

SEARCHED

FINGERPRINTS

BLOOD

HAIR

BONE

BLOOD

HAIR

BONE

SEARCHED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12945

12950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eoston</u>		c. LENGTH OF STAY IN 1b <u>15 hrs 10 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Queensbury</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>John</u>	Middle <u>Wayne</u>	Last <u>Flamer</u>
4. DATE OF DEATH	Month <u>December</u>	Day <u>16</u>	Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>September 6 1938</u>
9. AGE (In years last birthday) yrs. <u>2</u>	10. IF UNDER 1 YEAR Months <u>2</u>	11. IF UNDER 24 HRS. Days <u>0</u>	12. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md. - Talbot Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clayton John Baynard</u>		14. MOTHER'S MAIDEN NAME <u>Peggy Virginia Flamer</u> (See Birth Cert.)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>493X</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Malnutrition</u> (c) <u>Dehydration</u> since birth <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTO'S PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If neither, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Queensbury</u> (County) <u>Md.</u> (State) <u>12-1-58</u>	
21. I certify that I attended the deceased from <u>11-26-58</u> , 19 <u>58</u> , to <u>11-26-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-26</u> , 19 <u>58</u> , and that death occurred at <u>11155P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>205 Park Ave Eoston</u> DATE SIGNED <u>12-1-58</u>			
ACTUAL SIGNATURE <u>John E Baybutt</u>		M.D. <u>205 Park Ave Eoston</u> DATE SIGNED <u>12-1-58</u>	
PHYSICIAN'S NAME (Type) <u>John E Baybutt</u>		M.D. <u>205 Park Ave Eoston</u> DATE SIGNED <u>12-1-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 11/30/58		22b. DATE THEREOF <u>11/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORIAL Establishment <u>Commited Cem</u>		22d. LOCATION (City, town, or county) <u>Queensbury</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Archibald</u>		ADDRESS <u>Eoston, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thorne</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be delivered for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12949 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12951

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Delaware</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		b. COUNTY <i>Sussex</i>	
c. LENGTH OF STAY IN 1b <i>DoA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenwood Bridgeville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>		d. STREET ADDRESS <i>46 X-3</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Arthur</i>	Middle <i>M</i>	Last <i>Fiori</i>
4. DATE OF DEATH	Month <i>November</i>	Day <i>12</i>	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 17, 1922</i>
9. AGE (In years last birthday) <i>36</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salvage man</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Job work</i>	12. BIRTHPLACE (State or foreign country) <i>Delaware</i>
13. FATHER'S NAME <i>John B. Fiori</i>	14. MOTHER'S MAIDEN NAME <i>Mary Mireider</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>W. Franklin Cassell Easton MD</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple fractures of skull</i>
DUE TO <i>816X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Automobile accident</i>		(b) DUE TO <i>Automobile accident</i>	(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Two automobiles collided</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>8</i> p.m. <i>11-12 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Route 404 West of Bridgeville</i>
20f. (County) <i>Delaware</i>		(State) <i>Caroline</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dawson D. George</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Dawson D. George</i>		DATE SIGNED <i>11-12-58</i>	
220. BURIAL, CREMATION, OR REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>NOV. 15, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Bridgeville</i>		22d. LOCATION (City, town, or county) <i>Bridgeville, Delaware</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Franklin Cassell</i>		24a. REC'D BY REGISTRAR DATE NOV 1 1958	
ADDRESS <i>Easton, MD</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

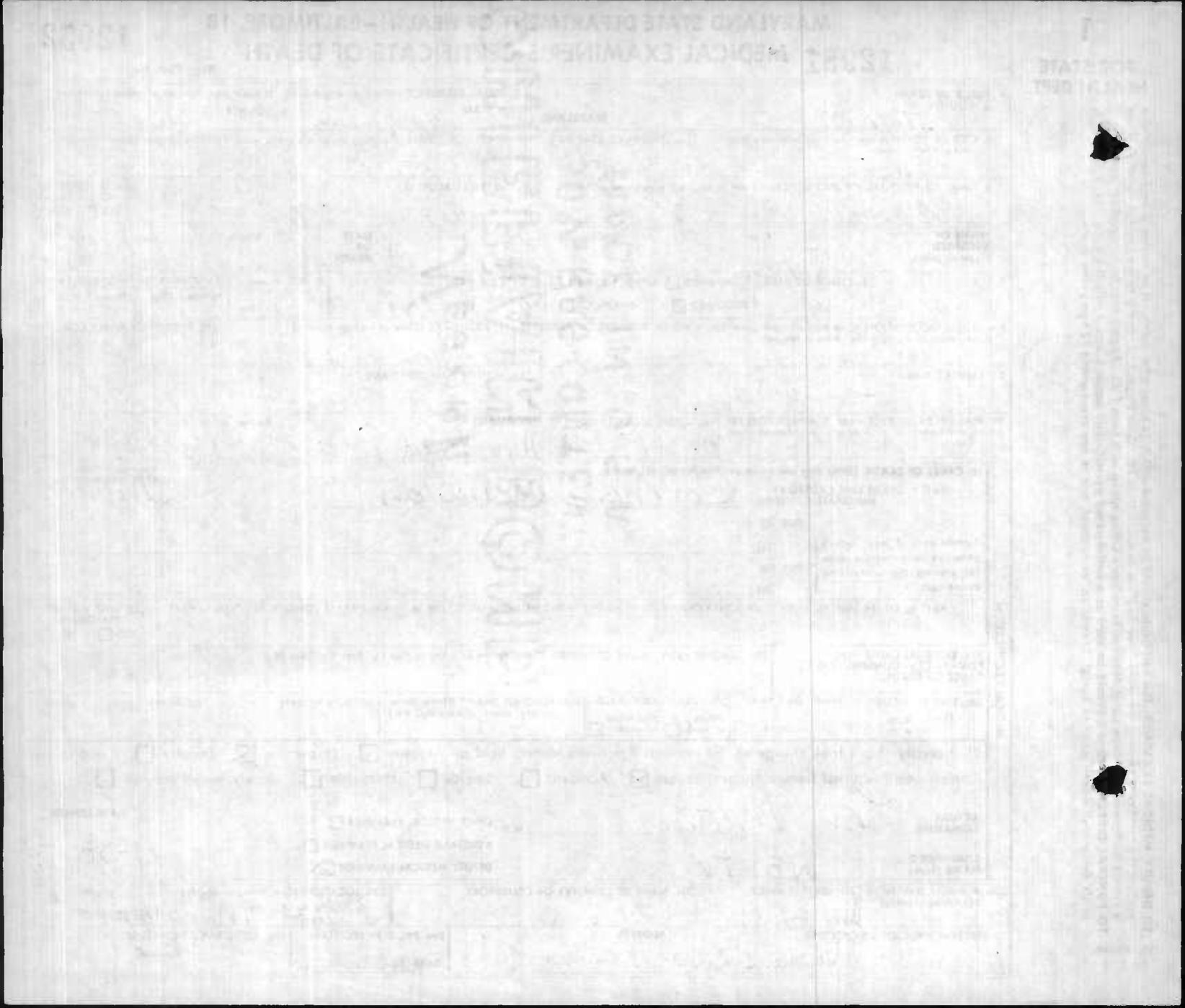
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>DOA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Oxford</i>		d. STREET ADDRESS <i>Morris Street</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>James Leonard Forrest</i>		First <i>J</i>	Middle <i>Leonard</i>	Lost <i></i>	4. DATE OF DEATH <i>November 20 1958</i>	Month <i>Nov.</i>	Doy <i>20</i>	Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 1, 1907</i>	9. AGE (In years last birthday) <i>51 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>			
13. FATHER'S NAME <i>Ernest B. Forrest</i>		14. MOTHER'S MAIDEN NAME <i>Elaine Pastors</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-16-1181</i>		17. INFORMANT <i>Mrs. Hazel Forrest Oxford, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Coronary Occlusion</i>		DUE TO <i>420.1</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.</i>		DUE TO <i>(b)</i>		DUE TO <i>(c)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Oxford</i>	(County) <i></i>	(State) <i></i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Lewis Meltz</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED <i>11-20-58</i>
EXAMINER'S NAME (Type) <i>WELTY</i>	22b. DATE THEREOF <i>Nov. 22, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Oxford</i>	22d. LOCATION (City, town, or county) <i>Oxford, Maryland</i>	(State) <i></i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice F. Neumann & Son</i>	ADDRESS <i>Easton, Md.</i>	24a. REC'D BY REGISTRAR <i>NON 25 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John E. Knapp</i>						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12952 CERTIFICATE OF DEATH 12953

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>		d. STREET ADDRESS <i>117 Colleghough St</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Anna Mary Franklin</i>		First	Middle	Lost	4. DATE OF DEATH <i>December 22 1958</i>	Month	Day	Year
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 18 1882</i>		9. AGE (In years last birthday yrs.) <i>76</i>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>N. W.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>George N. Collier Franklin</i>		14. MOTHER'S MAIDEN NAME <i>Emma Parsons</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>John Robert Franklin</i>		Address <i>Easton Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>155.1</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i>		b) <i>Caucium & J spel bladda</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Easton</i>		(County) <i>Easton</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>Dec 21 1958</i> to <i>Dec 22 1958</i> , that I last saw the deceased alive on <i>Dec 21 1958</i> , and that death occurred at <i>12:00 AM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Easton Maryland</i>		DATE SIGNED <i>22 Dec 1958</i>		
ACTUAL SIGNATURE <i>Thorston Harrison</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>Thorston Harrison</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 24 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Steel</i>		22d. LOCATION (City, town, or county) <i>Easton</i>		(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elvie Clark</i>		ADDRESS <i>6th & Main St</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 26 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Anna S. Mauer</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trouss permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE
HEALTH DEPT.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 236 12-12-58 et

14232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 09 x-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First LEONARD	Middle	Lost	4. DATE OF DEATH November 29 1958	Month	Day	Year
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH June 28, 1927	9. AGE (In years last birthday) 31 30 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Oyster Dredge	11. BIRTHPLACE (State or foreign country) Alachua County, Florida	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Fred Freeney	14. MOTHER'S MAIDEN NAME Lonia Hughes	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 3220	16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcoholism. - Exposure. DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
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ACTUAL SIGNATURE <i>Paul F. Guerin</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 12/1/58
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EXAMINER'S NAME (Type) Paul F. Guerin, M.D.	22b. DATE THEREOF 12/8/58	22c. NAME OF CEMETERY OR CREMATORIAL High Springs	22d. LOCATION (City, town, or county) High Springs, Fla.	(State)
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22e. BURIAL, CREMATION, REMOVAL (Specify) General	22f. ADDRESS Mrs. Paul F. Guerin 638 N. Gilmor St.	24a. REC'D BY REGISTRAR DEC 8 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
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23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Paul F. Guerin 638 N. Gilmor St.	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12954 CERTIFICATE OF DEATH

12955

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE VIRGINIA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WORCESTER EASTON		c. LENGTH OF STAY IN 1b 3 mos 1998		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SOUTH & HARRISON STS. EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEEMS		
3. NAME OF DECEASED (Type or print) MARIA		First LEE	Middle GOODWIN	
4. DATE OF DEATH Nov. 27	Month Nov.	Day 27	Year 1958	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1884	
9. AGE (In years last birthday) 74	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ROCKY MT., VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD L. GOODWIN	14. MOTHER'S MAIDEN NAME MARIA LOVE SMITH	Address CHARLOTTESVILLE, VIRGINIA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT MARY F. GOODWIN	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 58 , to Nov. 27 , 19 58 , that I last saw the deceased alive on Nov. 27 , 19 58 , and that death occurred at 7:20 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Donald F. Bartley M.D. ADDRESS (Street, city or town, state) 9 N. HANSON ST. DATE SIGNED 11-27-58				
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF DEC. 2, 1958	22c. NAME OF CEMETERY OR CREMATORIAL East End Cemetery	22d. LOCATION (City, town, or county) Wytheville, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice L. Newlin & Son	ADDRESS Easton, Md.	24a. REC'D BY REGISTRAR DATE DEC 8 '58	24b. REGISTRAR'S SIGNATURE Albert S. Kraus	

CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Pathologist

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Pathologist

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Date of Birth

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Pathologist

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Pathologist

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Date of Birth

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Pathologist

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Pathologist

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Date of Birth

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Pathologist

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Pathologist

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Date of Birth

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Pathologist

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Pathologist

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

80

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12953 CERTIFICATE OF DEATH 12954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Cordeline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Preston</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>05x-2</i>	
3. NAME OF DECEASED (Type or print) <i>Sherman T. Griffith</i>		4. DATE OF DEATH <i>15 7 1958</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 27, 1894</i>
9. AGE (In years lost birthday) <i>64 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>11</i> Days <i>7</i> Hours <i>05</i> Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Martin Griffith</i>		14. MOTHER'S MAIDEN NAME <i>Agnes Bardoe</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>414X</i>		16. SOCIAL SECURITY NO. <i>17. INFORMANT</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured mitral valve</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>Rheumatic mitral valvulitis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>219 S. Washington St.</i> (County) <i>Easton</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Patricia</i> , 19, to <i>19</i> , 19, that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>19</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>7 Nov 1958</i> DATE SIGNED	
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>11-9-58</i> 22c. NAME OF CEMETERY OR CREMATORIAL <i>Grove Cemetery</i> 22d. LOCATION (City, town, or county) <i>Preston, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry H. Hollingsworth PRESTON, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 10 '58</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12956 CERTIFICATE OF DEATH 14236
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i>		c. LENGTH OF STAY IN 1b <i>3 hrs. 40 min.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Queen Anne</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>McIrvine</i>		First <i>McIrvine</i>	Middle <i></i>	Lost <i>Hawkins</i>	4. DATE OF DEATH <i>November 26 1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>May 1896</i>	9. AGE (In years lost birthday) <i>62 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Luther Young</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Brown</i>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>331X</i>		16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i></i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	
				INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Easton Md.</i>	20f. (City or town) <i>Easton</i>	(County) (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>1 pm</i> , 19 <i>58</i> , to <i>9 pm</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>19 58</i> , and that death occurred at <i>9 pm</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Lenis McIrvine</i> M.D. ADDRESS (Street, city or town, state) <i>Easton Md.</i> DATE SIGNED <i>12/1/58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>11/30/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Easton, Md.</i>	22d. LOCATION (City, town, or county) <i>Hillsboro Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>James D. Daugherty, Easton, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>DEC 10 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Keeler</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12956

12955

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Talbot MARYLAND		MARYLAND b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
EASTON		3 1/2 da	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Memorial Hospital		x Royal Oak	
3. NAME OF DECEASED (Type or print)		First	Middle
Arthur		Freeman	
4. DATE OF DEATH		Month	Day
11		29	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
M		W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.	
Dec 23, 1878		77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
WATERMAN		SEAFOOD	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Ernest Parker Hall		Anna Kilmon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		213-22-7574	
17. INFORMANT		Address	
ALTON HALL, ROYAL OAK, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		3 days.	
IMMEDIATE CAUSE (a)		Myocardial Infarction	
DUE TO		Hypertensive Cardiovascular	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?	
		YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While Nat while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 Nov., 1958, to 29 Nov., 1958, that I last saw the deceased alive on 29 Nov., 1958, and that death occurred at 8:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE R. Bruce Thalh M.D.		Baptist St. Michaels, Md 11-30-58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12-2-58	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)	
Springfield Cemetery		Easton, Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
J. Hambleton Harrison, St. Michaels		24a. REC'D BY REGISTRAR	
Md		DEC 3 '58	
		24b. REGISTRAR'S SIGNATURE	
		Arthur S. Kline	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	10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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12957

CERTIFICATE OF DEATH

12957

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> 058-2	
3. NAME OF DECEASED (Type or print) <u>Mildred</u>		First <u>H</u> Middle <u>Jones</u> Last	4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <u>Nov. 5, 1896</u>	9. AGE (In years lost birthday) <u>62 yrs.</u>
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		12. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Isaac E. Hallowell</u>		14. MOTHER'S MAIDEN NAME <u>Maybelle Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>THURSTON JONES, FEDERALSBURG, MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>199.2</u> DUE TO <u>Carcinomatous - lympho epithelium</u> INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>primary site unknown</u> (c)		3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>(County)</u> <u>(State)</u>
21. I certify that I attended the deceased from <u>Nov. 13, 1958</u> to <u>1958</u> , that I last saw the deceased alive on <u>19 Nov 1958</u> , and that death occurred at <u>11:22 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED <u>20 Nov 58</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>NOV. 23, 1958</u> 22c. NAME OF CEMETERY OR CREMATORIUM <u>HILL CREST CEMETERY</u> 22d. LOCATION (City, town, or county) <u>FEDERALSBURG, MARYLAND</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Hampton & Son, Federalsburg, Md.</u>		24a. REC'D BY REGISTRAR ADDRESS <u>NOV 24 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be dated for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12958 CERTIFICATE OF DEATH

Reg. Dist. No. 12958

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>6 da.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. STREET ADDRESS <i>Main Street</i>				
3. NAME OF DECEASED (Type or print) <i>Hoger</i>		First <i>W.</i>	Middle <i>LARRimore</i>			
4. DATE OF DEATH <i>11/30/58</i>		Month <i>11</i>	Day <i>30</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>March 21, 1898</i>		9. AGE (In years lost birthday) <i>60 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>11</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fishing</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>William R. LARRimore</i>				
14. MOTHER'S MAIDEN NAME <i>Elizabeth Jewell</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				
16. SOCIAL SECURITY NO. <i>218-12-9147</i>		17. INFORMANT <i>Mrs. Warren Curing - North East, Md</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>204.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>Leukemia, myelogenous</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>203p</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 219 S. Washington St. 1 Dec 58</i>	20f. (City or town) <i>Rock Hall</i>	(County) <i>Kent Co</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M. from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Ollie Schmitz</i>		ADDRESS (Street, city or town, state) <i>219 S. Washington St. Rock Hall, Kent Co. Md.</i>			DATE SIGNED <i>1 Dec 58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/4/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Wesley Chapel Cem.</i>	22d. LOCATION (City, town, or county) <i>Rock Hall, Kent Co. Md.</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>MacLean Williams, Jr. (WESTERTOWN, MD)</i>		ADDRESS	24a. REC'D BY REGISTRAR <i>DEC 5 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12959

CERTIFICATE OF DEATH

REPLACEMENT 14239
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN lb 1 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Royal Oak	
3. NAME OF DECEASED (Type or print) Robert Edward		First Middle LeCompte	4. DATE OF DEATH NOV. 5, Month Day Year 1958
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY metal	9. AGE (In years last birthday) 55 yrs.
13. FATHER'S NAME Edward LeCompte		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) u kn		16. SOCIAL SECURITY NO. 160 10 9371	17. INFORMANT Mrs. Gladys M. LeCompte, Royal Oak, Md.
18. CAUSE OF DEATH [Enter only one cause per line of (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Myocardial Infarct Coronary occlusion	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE E.C.H. Schmidt		ADDRESS (Street, city or town, state) M.D. 295. Washington St. 22 Easton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/58	22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Schmidt		22d. LOCATION (City, town, or county) Easton, Maryland	
ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DEC 23 1958	24b. REGISTRAR'S SIGNATURE Charles S. Knott

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12960 CERTIFICATE OF DEATH 12959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>			d. STREET ADDRESS <i>112 South Aurora ST</i>		
3. NAME OF DECEASED (Type or print) <i>Mary A. Love</i>			4. DATE OF DEATH <i>November 14 1958</i>		
3. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 12 1882</i>	9. AGE (In years lost birthday) <i>76 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John Henry Dean</i>			14. MOTHER'S MAIDEN NAME <i>Harriett Mina Dulio</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>			16. SOCIAL SECURITY NO. <i>20-17-1102</i>		
17. INFORMANT <i>Mr. C. J. Butler</i>			Address <i>Easton Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>—</i> (b) DUE TO <i>—</i> (c) —					
INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY (Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State) <i>—</i>		
21. I certify that I attended the deceased from <i>13 Nov</i> , 19 <i>58</i> , to <i>14 Nov</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>14 Nov</i> , 19 <i>58</i> , and that death occurred at <i>5:25 P.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Thurston Harrison</i> M.D. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i> ADDRESS (Street, city or town, state) <i>Carver, Maryland 18 Nov 58</i> DATE SIGNED <i>18 Nov 58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 7 58</i>		22c. NAME OF CEMETERY OR CEMATORIAL <i>Spring Hill</i>	
22d. LOCATION (City, town, or county) <i>Carver</i>			23. FUNERAL DIRECTOR'S SIGNATURE <i>Reddick</i>		
24a. REC'D BY REGISTRAR DATE <i>NOV 19 '58</i>			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 20 Film 236 11-21-58 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12961

12960

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>CAROLINE</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>1 hr - 20 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FEDERALSBURG 05X-2</i>		d. STREET ADDRESS <i>Brooklyn Ave</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>MEMORIAL Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>John Leroy McDaniell</i>		First	Middle	Lost	4. DATE OF DEATH Month <i>11</i>	Month <i>7</i>	Doy <i>19</i>	Year <i>58</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 15, 1910</i>	9. AGE (In years less birthday) <i>48</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>MARY A. SMITH</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-16-1359</i>		17. INFORMANT <i>MARY R. McDANIEL, FEDERALSBURG, MD.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>982X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Localization of Brain - Hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH <i>27 days</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Stab wound through skull into brain</i>							
20c. TIME OF INJURY Hour <i>9:20</i>	Month, Day, Year p.m. <i>Nov. 7 1958</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, 1-20, (City or town) factory, street, office bldg., etc.) <i>At home</i>	(County) <i>Federalburg</i>	(State) <i>Caroline Md</i>				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Dawson D. George</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>11-8-58</i>			
EXAMINER'S NAME (Type) <i>Dawson D. George, M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov. 12, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Federal Hill Cemetery</i>	22d. LOCATION (City, town, or county) <i>Federalburg, Md.</i>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Trampum, Son.</i>		ADDRESS <i>Federalburg, Md.</i>	24a. REC'D BY REGISTRAR <i>Nov 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur G. Knob</i>				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12962

CERTIFICATE OF DEATH

Reg. Dist. No.

12961

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 22 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) W. Ibuse		First	Middle
4. DATE OF DEATH Melvin		Last	Month
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Dec 12 1906		9. AGE (In years last birthday) yrs. 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hyson D. Melvin		14. MOTHER'S MAIDEN NAME Mary J. Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.1 DUE TO <i>Generalized peritonitis</i> 10/18/58			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Perforated duodenal ulcer</i> 10/18/58 (c) DUE TO <i>Chronic duodenal ulcer</i> 8 years?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 322.1 <i>Chronic alcoholism</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 15, 1958</i> , to <i>Nov 7, 1958</i> , that I last saw the deceased alive on <i>Nov 7, 1958</i> , and that death occurred at <i>9:02 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur B. Cecil Jr.</i>		ADDRESS (Street, city or town, state) <i>Easton, Maryland</i>	
PHYSICIAN'S NAME (Type) ARTHUR B. CECIL JR.		DATE SIGNED <i>11/8/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 9/1958	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive		22d. LOCATION (City, town, or county) Lawndale	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Bouslais Greenbrier</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 12 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAY 1965

NAME

DEATH DATE

AGE

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF FUNERAL DIRECTOR

NAME OF CEMETERY DIRECTOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12963

CERTIFICATE OF DEATH

Reg. Dist. No.

12962

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>Nurlock</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Norman</i>	Middle <i>W.</i>	Last <i>Messick</i>			
4. DATE OF DEATH <i>November 3 1958</i>	Month <i>November</i>	Day <i>3</i>	Year <i>1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 22 1894</i>			
9. AGE (In years lost birthday) <i>64 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Former Farming</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	12. FATHER'S NAME <i>Perry S. Messick</i>					
13. MOTHER'S MAIDEN NAME <i>Clara Butler</i>	14. INFORMANT Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>289.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Multiple thromboses of lungs & legs. Collagen Disease, lymphangioma</i>						
			INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. <i>219 S. Washington St. 218158</i>	(County) ADDRESS (Street, city or town, state)	(State) DATE SIGNED
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M., from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>	PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>		ADDRESS (Street, city or town, state) <i>Easton, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>11/6/58</i>	22b. DATE THEREOF <i>11/6/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Washington Cemetery</i>	22d. LOCATION (City, town, or county) <i>Nurlock, Md.</i>	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey Williamson - Federalsburg Md.</i>	ADDRESS <i>Harvey Williamson - Federalsburg Md.</i>	24a. REC'D. BY REGISTRAR <i>NOV 12 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Clara S. Kline</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12979

CERTIFICATE OF DEATH

12963

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neguitt		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neguitt		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH FEB. 15 1875	9. AGE (In years ^{last birthday}) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME John S. NEWNAM		14. MOTHER'S MAIDEN NAME Emily Shores						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-32-086		17. INFORMANT Miss Edith Newnam		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X DUE TO <i>Pyoplasia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pulmonary Tuberculosis</i> DUE TO (c) 367.						INTERVAL BETWEEN ONSET AND DEATH 5 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertensive Cardiovascular Dis.</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>12/12/1957</i> to <i>12/12/1958</i> that I last saw the deceased alive on <i>12/12/1957</i> and that death occurred at <i>10:30 AM</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>R. Howell Wroth</i>		M.D.		ADDRESS (Street, city or town, state) <i>Box 487, St. Michaels, Md 117358</i>		DATE SIGNED <i>12/12/1958</i>		
PHYSICIAN'S NAME (Type) <i>Dr. R. Howell Wroth</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 15 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Neguitt Cemetery</i>		22d. LOCATION (City, town, or county) <i>Neguitt Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice F. Newnam, Son</i>		ADDRESS <i>Easton, Md.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		
VS A15 (4) 15M 9/55				DATE <i>Nov 14 1958</i>				

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12980

CERTIFICATE OF DEATH

12964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE St. Michael's, Md b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAEL'S		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Thomas	Middle William	Last Palmer
4. DATE OF DEATH	Month Nov	Day 15	Year 1958
5. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 30, 1884
9. AGE (in years last birthday) yrs. 71	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Zabarer	10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (State or foreign country) Bogman, Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME Charles Elbert Palmer		
14. MOTHER'S MAIDEN NAME Mary Emma Moody	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none.		
16. SOCIAL SECURITY NO. 216-09-3261	17. INFORMANT Mollie Palmer, St. Michael's, Md	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177x DUE TO Carcinomatosis INTERVAL BETWEEN ONSET AND DEATH 3 mon.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma of prostate (c) 14p.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19	Month Nov	Day 15	Year 1958
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) St. Michael's	(County) Md (State) MD
21. I certify that I attended the deceased from 12-10-58 , 1958, to 15-Nov-58 , 1958, that I last saw the deceased alive on 14 Nov 58 , 1958, and that death occurred at 1:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE R. Lane Whittle ADDRESS (Street, city or town, state) Box 487, St. Michael's Md DATE SIGNED 11-12-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Memorial Park Cemetery, St. Michael's
22d. LOCATION (City, town, or county) St. Michael's		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Hampton Harrison		ADDRESS St. Michael's, Md	24a. REC'D BY REGISTRAR Nov 25 '58
			24b. REGISTRAR'S SIGNATURE Clinton S. Lane

CERTIFICATE OF DEATH

MARCH 1941

NAME

DEATH DATE

DEATH PLACE

DEATH DATE

DEATH PLACE

DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your information. Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12964 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12965

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Talbot MARYLAND		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 27 HR.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 EASTON	
3. NAME OF DECEASED (Type or print) FRANK		d. STREET ADDRESS 1531 S. Washington	
First M		Middle Frederick	
Last Poland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M		4. DATE OF DEATH Nov. 16 1958	
6. COLOR OR RACE W		5. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8-20-1895	
7. IMMEDIATE CAUSE 900.0		9. AGE (in years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Eng-Revore Copper		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry W. Poland		14. MOTHER'S MAIDEN NAME Clara Tousby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 139-01-6302- MRS. MARY Poland -	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line) or (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause first. DUE TO (c) Severe brain injury Fall downstairs	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 11-15 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) EASTON	
(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Lewis WELTY		DATE SIGNED 11-17-58	
EXAMINER'S NAME (Type) WELTY		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL/CREMATION, REMOVAL (Specify) 11-20-58		22b. DATE THEREOF 11-20-58	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hollywood Cemetery, Baltimore		22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE R. Frank J. Carroll, Easton, Md.		24a. REC'D BY REGISTRAR DATE NOV 19 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Keas		24c. ADDRESS 807 H. C.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12965 CERTIFICATE OF DEATH 12965
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>26 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Preston</i>		d. STREET ADDRESS <i>05 x-2</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Velma</i>	Middle <i>Reese</i>	4. DATE OF DEATH Month <i>December</i> Day <i>21</i> Year <i>1958</i>	Month <i>December</i> Day <i>21</i> Year <i>1958</i>	5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 5 1899</i>	9. AGE (In years lost birthday) <i>59 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Seamstress</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>John W. Christopher</i>		14. MOTHER'S MAIDEN NAME <i>Louise Butler</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>John Reese, Preston, Md.</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Mastostosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Gastritis & Pneumonia</i> DUE TO (c) <i>Gastritis & Stroke</i>						INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Preston</i>		(County) <i>Caroline</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>7/1</i> , 19 <i>76</i> , to <i>11/21</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10/20</i> , 19 <i>58</i> , and that death occurred at <i>11:30 P.M.</i> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <i>Harold B. Plummer</i>		M.D.		ADDRESS (Street, city or town, state) <i>P.O. Box #158 Preston, Md.</i>		DATE SIGNED <i>11/25/58</i>				
PHYSICIAN'S NAME (Type) <i>Harold B. Plummer</i>										
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Buried Nov 24</i>		22b. DATE THEREOF <i>Nov 24</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Denton</i>		22d. LOCATION (City, town, or county) <i>Denton</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. V. Moore & Son</i>		ADDRESS <i>Denton</i>		24a. REC'D BY REGISTRAR <i>Nov 2 B '58</i>		24b. REGISTRAR'S SIGNATURE <i>Caroline & Thorne</i>				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12966 CERTIFICATE OF DEATH

Reg. Dist. No. 12967

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>2 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		3. VOL-4						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>4210 Lockhaven Blvd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <i>Joseph</i>		First <i>VINCENT</i>	Middle <i>Reilly</i>	Last <i>Reilly</i>	4. DATE OF DEATH <i>November 13 1958</i>	Month <i>November</i>	Day <i>13</i>	Year <i>1958</i>				
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-4-1889</i>		9. AGE (In years last birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railway Express Agency</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
13. FATHER'S NAME <i>JAMES REILLY</i>		14. MOTHER'S MAIDEN NAME <i>MARY JANE KENNEDY</i>		Address <i>Raven Blvd.</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>714-03-4045</i>		17. INFORMANT <i>Mrs. Gertrude E. Reilly, 4210 Loch</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>M.D.</i>		(County) <i>219 S. Washington St.</i>		(State) <i>1958</i>		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 9 ⁴⁰ / ₆₀ M, from the causes and on the date stated above.												
ACTUAL SIGNATURE <i>E. C. Schmidt</i>		ADDRESS (Street, city or town, State) <i>219 S. Washington St. 1958</i>		DATE SIGNED <i>16/11/58</i>								
PHYSICIAN'S NAME (Type) <i>E. C. Schmidt</i>		22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>										
22b. DATE THEREOF <i>Nov. 18/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>New Cathedral</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>29, Md.</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke Funeral Directors</i>		ADDRESS <i>4101 Edmondson Ave</i>		24a. REC'D BY REGISTRAR <i>NOV 17 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Carlene S. Turner</i>						

41 38991-573830 7474490 37A2 01420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12967

CERTIFICATE OF DEATH

12968

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>31 da.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		d. STREET ADDRESS <i>515 Market St.</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>515 Market St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>MARY</i>		First <i>A.</i>	Middle <i>Scot</i>	Lost <i>Scot</i>	4. DATE OF DEATH <i>Nov. 24 1958</i>	Month <i>Nov.</i>	Day <i>24</i>	Year <i>1958</i>				
5. SEX <i>fe</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 1862</i>		9. AGE (In years lost birthday) <i>96</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>		IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>						
13. FATHER'S NAME <i>Matthew Chilton</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Willis</i>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> S. V. Disease.												
DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fist Smell Nest of German st.</i>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) <i>Fall of house</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <i>10/24</i> , 1958, to <i>11/24</i> , 1958, that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>EASTON, MARYLAND</i>												DATE SIGNED
ACTUAL SIGNATURE <i>Howard F. Kinnaman</i> M.D.												
PHYSICIAN'S NAME (Type) <i>HOWARD F. KINNAMAN</i>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL NOV 27, 1958</i>		22b. DATE THEREOF <i>1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>DENTON</i>		22d. LOCATION (City, town, or county) (State) <i>DENTON MD</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Virgil Moore & Son</i>		ADDRESS <i>Denton</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 4 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Calling L. Kinnan</i>						

CERTIFICATE OF DEATH

Date of Death

Place of Death

Cause of Death

Time of Death

Age at Death

Sex

Race

Marital Status

Occupation

Employment

Employer

Address

City

State

Zip Code

Country

Phone Number

Relationship to Deceased

Signature

Title

Address

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNA3. Page 5 may be retained for your information. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and return **within 72 hours after death.**

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12968 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12969

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 140		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Memorial Hospital		d. STREET ADDRESS 131 VINE ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wesley		First	Middle	Lost	4. DATE OF DEATH NOV 12 1958
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 36 yrs.	9. AGE (In years from today) 36 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Robert Smith	14. MOTHER'S MAIDEN NAME Mary Wisher		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Emmett Smith	Address Easton, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH immed.
1420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) cirrhosis of liver		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>Louis S. Welty</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 11-12-58
EXAMINER'S NAME (Type) Louis S. Welty		

22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 11/17/58	22c. NAME OF CEMETERY OR CREMATORY Lordstown Cem	22d. LOCATION (City, town, or county) Easton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>James S. Dashiell</i>	ADDRESS 426 Main Street, Easton, Md.	24a. REC'D BY REGISTRAR NOV 19 '58	24b. REGISTRAR'S SIGNATURE Albert S. Thomas

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HEAD TO STATED COUNTRY GRANADA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12969

CERTIFICATE OF DEATH

12970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON	c. LENGTH OF STAY IN 1b 4 da.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg	d. STREET ADDRESS 221 DENTON ROAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial	3. NAME OF DECEASED (Type or print) BABY CHRISTINE, R/VISTA STANLEY	First Middle Last	4. DATE OF DEATH 11-6-58			
5. SEX F	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME MAURICE STANLEY	14. MOTHER'S MAIDEN NAME Maetha Ricketts	Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MAURICE STANLEY, FEDERALSBURG, MD.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 76a5 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 4 da 4 da			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 205 Earle Ave EASTON MD	20f. (City or town) FEDERALSBURG	(County) MARYLAND	(State) MARYLAND	
21. I certify that I attended the deceased from 11-2-58 to 11-6-58 , that I last saw the deceased alive on 11-6-58 , and that death occurred at 12N M, from the causes and on the date stated above. ACTUAL SIGNATURE John E Bayburt						
PHYSICIAN'S NAME (Type) John E Bayburt	ADDRESS (Street, city or town, state) 205 Earle Ave EASTON MD					DATE SIGNED 11-8-58
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF NOV. 8, 1958	22c. NAME OF CEMETERY OR CREMATORIUM FEDERAL HILL CEMETERY	22d. LOCATION (City, town, or county) FEDERALSBURG, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton & Son, Federalsburg, Md.	ADDRESS 2080202XV1	24a. REC'D BY REGISTRAR DATE NOV 13 '58	24b. REGISTRAR'S SIGNATURE Carroll S. Trans			

CERTIFICATE OF DEATH

B-1000-1980

Name of deceased person: **JOHN H. HARRIS**Date of death: **1980/07/10**Place of death: **Hospital**Name of physician: **DR. JOHN H. HARRIS**Cause of death: **Cardiac arrest**Name of hospital: **Hospital** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of physician: **DR. JOHN H. HARRIS** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of hospital: **Hospital** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of physician: **DR. JOHN H. HARRIS** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of hospital: **Hospital** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of physician: **DR. JOHN H. HARRIS** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of hospital: **Hospital** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of physician: **DR. JOHN H. HARRIS** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of hospital: **Hospital** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of physician: **DR. JOHN H. HARRIS** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of hospital: **Hospital** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of physician: **DR. JOHN H. HARRIS** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of hospital: **Hospital** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of physician: **DR. JOHN H. HARRIS** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of hospital: **Hospital** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of physician: **DR. JOHN H. HARRIS** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of hospital: **Hospital** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**Name of physician: **DR. JOHN H. HARRIS** Address: **1000 University** City: **Baltimore** State: **Maryland** Zip: **21204-2200**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12970

CERTIFICATE OF DEATH

Reg. Dist. No.

12971

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Talbot				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton, Md.		d. STREET ADDRESS 168 Graham st				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 68 Graham st				d. STREET ADDRESS 168 Graham st		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Georgie Anna		First Stanton	Middle Stanton	Last Stanton	4. DATE OF DEATH 11/23/1958	Month 11	Day 23	Year 1958		
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/1913	9. AGE (In years last birthday) 45 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Robert J. Banks		14. MOTHER'S MAIDEN NAME Charlotte Green		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH Recent	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) EASTON	(County) MARYLAND	(State) MD.
21. I certify that I attended the deceased from alive on 9/12, 1958 , and that death occurred at 4A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) EASTON		DATE SIGNED 11-25-58						
ACTUAL SIGNATURE <i>Shepard Jr</i>		PHYSICIAN'S NAME (Type) SHEPARD KRECH JR		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/58	22c. NAME OF CEMETERY OR CREMATORIALY Trappe, Cam	22d. LOCATION (City, town, or county) Trappe	(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Osthelder</i>		ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause				

FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, striking the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your information. **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15MI
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12571 MEDICAL EXAMINER'S CERTIFICATE

12972

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Talbot								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN lb 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton		d. STREET ADDRESS 514 S.Aurora St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 514 S.Aurora St											
3. NAME OF DECEASED (Type or print)		First MARTHA	Middle H. STEVENSON	Lost	4. DATE OF DEATH Nov. 15 1958	Month Nov.	Dey 15	Year 19 58			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1915	9. AGE (In years from birthday) 43 <input checked="" type="checkbox"/> yrs.	IF UNDER 1YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 6, 1916								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant & housewife			10b. KIND OF BUSINESS OR INDUSTRY Women's apparel			11. BIRTHPLACE (State or foreign country) Ohio			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James E. Hartley			14. MOTHER'S MAIDEN NAME Maude B. Overly								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 280-03-7000			17. INFORMANT Mr. George R. Stevenson			Address Easton Md.		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <i>Calculus aortic stenosis & insufficiency</i>						INTERVAL BETWEEN ONSET AND DEATH		
421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)		
19											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Larry Melty</i>		EXAMINER'S NAME (Type) MELTY		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11-17-58	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1958		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Woodlawn Memorial Park		22d. LOCATION (City, town, or county) nr Easton, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				24a. REC'D BY REGISTRAR DEC 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

REPLACEMENT CERTIFICATE FROM DR. WELTY. 12/2/58

- Film #736
mb/ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12972

CERTIFICATE OF DEATH

Reg. Dist. No.

12973

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>7 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>	
3. NAME OF DECEASED (Type or print) <u>Paula</u>		d. STREET ADDRESS <u>RIVER ROAD</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) yrs. <u>NOVEMBER 21 1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Leon Banks</u>		14. MOTHER'S MAIDEN NAME <u>Alice Joyce Strawberry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ALICE J. STRAWBERRY, FEDERALSBURG, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>M.D.</u>		20f. (City or town) (County) <u>205 S. Main Ave</u> (State) <u>MD.</u>	
21. I certify that I attended the deceased from <u>11-21, 1958</u> to <u>11-27, 1958</u> , that I last saw the deceased alive on <u>11-26, 1958</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Baybutt</u>		ADDRESS (Street, city or town, state) <u>205 S. Main Ave</u>	
PHYSICIAN'S NAME (Type) <u>John E. Baybutt</u>		DATE SIGNED <u>12-1-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 8, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>FEDERAL HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Grumpton & Sons Federalsburg</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '58</u>	
ADDRESS <u>208016/XVI</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12903 CERTIFICATE OF DEATH

Reg. Dist. No. 12904

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		b. COUNTY <u>TALBOT</u>			
c. LENGTH OF STAY IN 1b <u>12 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ST. MICHAELS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		d. STREET ADDRESS <u>1204 CHEW AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <u>WILLIAM</u>	Middle <u>H.</u>	Last <u>SUMMFIELD</u>		
4. DATE OF DEATH	Month <u>Nov</u>	Day <u>5</u>	Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 30 1889</u>		
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <u>69 yrs.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PATROLMAN, Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Phila Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM H. SUMMFIELD</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE Diddings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>214-30-95664</u>			
17. INFORMANT <u>Laura E. Summfield, St. Michaels</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <u>(b) coronary artery disease</u> <u>(c) arteriosclerosis (Generalized)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5 Stevens</u>	20f. (City or town) <u>St. Michaels</u>	(County) <u>Calvert</u>	(State) <u>Md</u>
21. I certify that I attended the deceased from <u>Jan 1958</u> to <u>St. Michaels 1958</u> , that I last saw the deceased alive on <u>5 October 1958</u> , and that death occurred on <u>10 1958</u> AM, from the causes and on the date stated above. ACTUAL SIGNATURE <u>R. E. Summfield</u> ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md 20658</u> DATE SIGNED PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL <u>Hillside Cemetery</u>	22d. LOCATION (City, town, or county) <u>Roslyn</u>	(State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Hambleton, Harrison St. Michaels</u>		ADDRESS <u>me</u>	24a. REC'D BY REGISTRAR DATE <u>NOV 1 0 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

81. PROBLEMS OF THE STATE OF CALIFORNIA
CERTIFICATE OF DEATH

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

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DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12973

CERTIFICATE OF DEATH

12974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 6 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. STREET ADDRESS Ridgely	
3. NAME OF DECEASED (Type or print) Dennis		First D , Middle T. , Last Thomas	4. DATE OF DEATH 11 - 13 - 1958
5. SEX Male.	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1880
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months 0 , Days 0	11. IF UNDER 24 HRS. Hours 0 , Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred Thomas	
14. MOTHER'S MAIDEN NAME Mary Groce		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Clark Huff, daughter - Ridgely, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Aphoplexy arteritisclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11/13/58
20f. (City or town) EASTON		(County) Md.	
(State) MD			
21. I certify that I attended the deceased from 11/13/58 to 11/13/58 , that I last saw the deceased alive on 11/13/58 , and that death occurred at 8 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) EASTON, Md		DATE SIGNED NOV 19 '58	
ACTUAL SIGNATURE P. E. Cox		PHYSICIAN'S NAME (Type) P. E. Cox MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/58	22c. NAME OF CEMETERY OR CREMATORIAL Thomas Baril Cemetery
22d. LOCATION (City, town, or county) Ridgely, Md.		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boucais Greensboro, Md		ADDRESS Arthur S. Trahan	
24a. REC'D BY REGISTRAR DATE NOV 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 BALTIMORE—DEPARTMENT OF STATE—INDIA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12974

CERTIFICATE OF DEATH

Reg. Dist. No.

12975

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Easton		d. STREET ADDRESS —				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Horace		First	Middle	Last	4. DATE OF DEATH TOWNSEND	Month 11	Day 10	Year 1958		
5. SEX M	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1866		9. AGE (In years last birthday) yrs. 92	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William		14. MOTHER'S MAIDEN NAME Townsend		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 493X		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Frances Kellum		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, right lung		DUE TO 493X		INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Advanced arteriosclerosis.		(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Advanced arteriosclerosis.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —								
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> —		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 2195 West 117th St. 10 Nov 58		20f. (City or town) Easton		(County) Easton	(State) Md.	
21. I certify that I attended the deceased from alive on 11/15/58 , and that death occurred at 11/15/58 A.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 2195 West 117th St. 10 Nov 58				DATE SIGNED 11/15/58
ACTUAL SIGNATURE E.C.H. Schmidt										
PHYSICIAN'S NAME (Type) E.C.H. Schmidt										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/58		22c. NAME OF CEMETERY OR CREMATORIUM Unionville Cem.		22d. LOCATION (City, town, or county) Easton		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE James B. Hashill		ADDRESS Boston, Md.		24a. REC'D BY REGISTRAR NOV 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Moore				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12975

CERTIFICATE OF DEATH

12976

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE	
Talbot MARYLAND		Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL	c. LENGTH OF STAY IN lb 5 hrs 37 min	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital	d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) James	First K.	Middle Woodward	4. DATE OF DEATH Nov. 29 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 3, 1933
9. AGE (In years last birthday) 27 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVER	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Mr. James Clark Woodward	14. MOTHER'S MAIDEN NAME Leona Marvel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-30-9246	17. INFORMANT Janet Woodward	Address Ridgely Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) bleeding due to ruptured cystic artery (c) congenital aneurism			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 2:12 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE E.C.H. Schmidt			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/58	22c. NAME OF CEMETERY OR CREMATORIAL Allerton
22d. LOCATION (City, town, or county) Hawthorne Md.		22e. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Boeckelis Greensboro, Md.		24a. REC'D BY REGISTRAR DEC 2 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Traus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12976

CERTIFICATE OF DEATH

Reg. Dist. No.

12977

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>20 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		d. STREET ADDRESS <i>Rt # 3 Box 45</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>				d. STREET ADDRESS <i>Rt # 3 Box 45</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Mattie</i>		First	Middle	Last	4. DATE OF DEATH <i>Young</i>	Month	Day	Year		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 9, 1875</i>		9. AGE (In years last birthday) <i>83</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Solomon Wilson</i>		14. MOTHER'S MARRIED NAME <i>Isabelle</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>157x</i>		DUE TO <i>Adenocarcinoma of Pancreas</i>				INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy	Year	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>219 S. Washington St.</i>	(County) <i>Easton</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from alive on <i>July 19</i> to <i>July 19</i> , that I last saw the deceased and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>219 S. Washington St. Easton, Md.</i>				
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>		DATE SIGNED <i>20 Nov 58</i>								
PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/24/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Joy Town Cem.</i>		22d. LOCATION (City, town, or county) <i>Easton</i>		(State) <i>Rt 3, Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Dashill</i>		ADDRESS				24a. REC'D BY REGISTRAR <i>Arthur S. Hayes</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hayes</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

